Expressed emotion in professional relationships

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Purpose of review

Expressed emotion refers to the amount of critical comments, hostility or emotional overinvolvement of a caregiver towards clients with severe and enduring psychiatric disorders. In family members, it is a well-established measure to assess the affective climate, and is a good and reliable predictor of patients' functioning. Expressed emotion research has recently been expanded towards formal relationships. This paper reviews the existing expressed emotion literature in relationships between professional caregivers and their clients.

Recent findings

The findings confirm that in professional caregivers, high expressed emotion attitudes can be present and that these attitudes can also have a significant influence on outcomes. Although professional caregivers are not usually emotionally overinvolved, 'role confusion' does exist. The limited information concerning correlates with expressed emotion suggests that expressed emotion is related to the clients' level of functioning and with the amount of openness and internal attribution from the professionals' perspective. As for families, training intervention programmes for professionals were developed that aimed to lower the amount of expressed emotion.

Summary

Compared with the expressed emotion research in family relationships, this research line is still in its infancy. However, the expressed emotion construct seems to be very useful to chart the emotional climate between clients and professional caregivers. The future of the construct of expressed emotion in this field will probably depend upon the possibility of predicting the wellbeing, the functioning and the relapse of clients.

Keywords

client-professional caregiver dyad, expressed emotion, relationship

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Abbreviations

CFI	Camberwell Family Interview
EE	expressed emotion
EOI	emotional overinvolvement
FMSS	Five-Minute Speech Sample

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Introduction

'... it is unrealistic to expect family members to cope with schizophrenic patients without instruction and training. The same obviously applies to professional staff ...' [1]

A substantial amount of research has been conducted concerning the influence of the family climate, as assessed by the construct of expressed emotion (EE), on the course of severe mental disorders [2-5]. EE refers to the affective attitudes and behaviours characterized by critical comments, hostility and emotional overinvolvement (EOI) from (in)formal caregivers towards patients. It has demonstrated that EE is a reliable and robust outcome predictor in patients with a broad range of severe psychiatric disorders and physical illnesses [6]. This means that patients living in high EE environments (high criticism, presence of hostility or the presence of EOI) have a higher relapse risk than patients living in low EE environments. On the basis of EE research, many family intervention programmes have been developed, which reduce relatives' criticism, hostility and EOI, and patients' relapse rates [7-9]. However, some of the controlled trials have failed to demonstrate an advantage of family interventions on routine interventions [9].

The power and strength of the EE construct depends on its impressive predictive validity. According to Hooley [10], the effect size of EE on relapse ($r=0.31$) is comparable with the effect size of aspirin effectiveness on the prevention of heart attacks ($r=0.34$). In addition, the EE construct is a good tool for charting the complex interaction patterns between patients and (in)formal caregivers.

Although EE was originally studied in a family context, EE research has been expanded to evaluate the affective climate in a professional caregivers' context. Already in the 1980s, a few researchers had noted that not only the attitudes of family members but also the attitudes of professional caregivers could influence the clients' functioning [11]. Berkowitz and Heintz [12] described that successful multidisciplinary teams tend to develop interaction patterns that resemble the interaction patterns of low EE family members. Moreover, Simpson [13] argued that professional caregivers could not only show low EE attitudes, but also feelings like hostility and criticism.

In this article, the EE literature concerning professional caregivers will be reviewed. The presence and the content of EE in professional–client relationships, the association with relapse and with clients' and professional caregivers' characteristics will be discussed. It will also be argued that EE knowledge may be used in training programmes targeted to professional caregivers. As only a small number of papers focusing on EE in the client–professional caregiver dyad have been published in the past 2 years, this paper presents a more general overview of the existing literature on this topic.

Expressed emotion in professional caregivers

Watts (cited in [14]) and Herzog [15] were the first researchers to describe the affective climate between professional caregivers and clients by means of the EE construct. Using a modified version of the Camberwell Family Interview (CFI) [16,17], they indeed found high EE attitudes in professional caregivers.

Several researchers have been able to confirm that high EE is not limited to family members of psychiatric patients and that professional caregivers can also show high EE attitudes [14,15,18,19•,20–30,31•]. In several studies the presence of high EE ranges from a low of 0% [19•] up to a high of 62% among professionals, mostly nurses [15]. Therefore, there is a large difference in the percentages of high EE scores; they may be caused by differences between the caring facilities assessed (e.g. hostels, day hospitals, residential facilities), between clients (e.g. chronic psychiatric patients, patients with schizophrenia) and between different EE assessment methods (e.g. CFI, Five-Minute Speech Sample (FMSS)). Available data show that assessments made using the FMSS result in a greater amount of high EE than assessments made with the CFI. The difference in threshold for high EE between the FMSS (only one critical comment) and the CFI (six or more critical comments) might explain this finding [19•].

Low EE professionals can control their own feelings, are warm and capable of motivating their clients and have a good balance between over- and understimulation of clients. They can establish clear boundaries, understand clients' difficulties and motivate them to be as independent as possible [22,31•].

The research carried out so far points to differences in the content of family members' versus professionals' EE scores. Although professional caregivers and relatives both express a comparable amount of criticism and hostility, the first group is significantly less emotionally over-involved than family members [22,27,29]. Only Stark and Siol [28] and Van Humbeeck *et al.* [31•] found evidence for the presence of EOI. The absence of EOI is probably a

consequence of the professional caregivers' professional background, the higher caseload and the lower frequency and intensity of contact between professional caregivers and clients compared with family members.

However, Van Humbeeck *et al.* [31•] described specific professionals' attitudes, which may be considered as emotionally overinvolved behaviours. In particular, these attitudes were characterized by the absence of a professional distance between the professional caregiver and the clients. Sometimes the boundaries between professional and private dimensions became blurred, and professionals expressed themselves as if they were a parent, partner or a very close friend of the client. This phenomenon, which by definition cannot be ascertained in family studies, was called 'role confusion', and the study researchers recommended the incorporation of this dimension into the EE coding system for professional caregivers as a separate scale in the EOI scale.

As in family research, high EE attitudes are not limited to professional caregivers of clients with severe psychiatric disorders. Studies with professional caregivers of clients with learning disabilities have also shown high EE attitudes [32–35], which are mainly based on the high number of critical comments and the presence of hostility. Although EOI occurred rarely, there was evidence of role confusion in the study of Van Humbeeck *et al.* [35].

In a professional context, the CFI [16,17] is regarded as the best instrument for charting the emotional climate between a professional caregiver and a client [36•]. This semi-structured interview collects factual and attitudinal information about the onset and development of the present illness episode, the illness history, irritability and quarrelling, the patient's symptomatology and the quality of the relationship. A qualified rater then codes the audiotaped CFI on five scales: (1) critical comments (a frequency count); (2) hostility (a 4-point scale: 0–3); (3) positive remarks (a frequency count); (4) EOI (a 6-point scale: 0–5); and (5) warmth (a 6-point scale: 0–5). Formal caregivers are classified as high on the EE index if they make six or more critical comments, if they are hostile (score 1–3), or if they have a score of three or more on the EOI scale [17,37]. However, because it takes much time to administer and code the CFI, alternative instruments have been developed, including the FMSS [38], the Level of Expressed Emotion [39] and the Perceived Criticism Scale [40]. Although the FMSS seems a good alternative [24], the CFI still remains the best instrument to assess the emotional climate in a professional context [36•].

In most research, EE is only assessed from the professional caregivers' perspective. However, some

studies have demonstrated that criticism perceived by a patient is a very good predictor of the patient's relapse rate [40]. In our own research (G. Van Humbeeck, 2002, unpublished PhD dissertation), which gives an overview of the existing EE literature in formal and informal relationships and presents research concerning the presence of EE in professional relationships (professionals of clients with schizophrenia, living in sheltered living and clients with learning disabilities, living in residential facilities), we found a significant association between the CFI criticism score and two alternative EE measures, namely the Level of Expressed Emotion [39,41] ($r=0.36$, $P<0.01$) and the Perceived Criticism Scale [40] ($r=0.45$, $P<0.01$). However, before these instruments can be considered good and reliable alternatives, it is important to establish whether the instruments do have the power to predict clients' outcomes. This research also contained unpublished data concerning a comparison of EE instruments in a professional relationship and concerning the association between EE and measures like professionals' burnout, job satisfaction and well-being. Future research will certainly need to involve the evaluation of clients' perception of criticism in the attitudes of professionals.

The association between expressed emotion and clients' and professional caregivers' characteristics

Until now most EE research in client-professional dyads has been concentrated on the presence of EE in these relationships; less attention is paid to EE correlates. The few studies that have tried to study these variables do not provide univocal results. Whereas some researchers report significant positive associations between EE and symptoms [23,26,27], other researchers did not confirm this relationship [22,25,29,42**]. There is more agreement about the positive relationship between high EE and a poorer level of functioning [19**,20,42**]. High EE has also been found to be positively associated with clients' age, whereas a negative association was found with the social network size [42**]. Disappointingly, the association between EE and specific clients' characteristics, such as sex and physical attractiveness, has not yet been investigated. Even the amount of time that professionals and clients spend together can be associated with EE; it seems that high EE professionals spend significantly more time with clients than low EE professionals [22,42**].

Still less information is available concerning correlates between EE and professional caregivers' characteristics. Some studies have found a positive relationship between EE and the intention to leave the workplace within 12 months [22,26]. As in family research [43-46], the study of formal relationships suggested that attributions of clients' symptoms might influence the EE score

[19**,34]. This means that symptoms that are perceived as internal and controllable by clients will significantly provoke more criticism and hostility than symptoms that are attributed as external and uncontrollable by clients. Another interesting finding is the relationship between EE and openness. As both Hooley and Hiller [47] and Leff and Vaughn [37] found in family research, Moore *et al.* [25] and Van Humbeeck *et al.* [36*] were able to confirm that low EE professionals were more open than high EE professionals; openness was measured by a Big Five Questionnaire [48]. An open professional is flexible and curious towards new situations and does not conform with existing rules. Therefore, as in family research, openness might be a very important characteristic of a low EE climate.

The association between expressed emotion and functioning of clients

In family research, the strength of the EE construct not only lies in its power to discriminate between high and low EE, but above all in its robust and reliable prediction of relapse. The future value of this construct depends on its power to predict the clients' course of illness. Although research in this field is very limited, available data do confirm the predictive validity of EE for the clients' social functioning and well-being [18,20,27,29]. Ball *et al.* [18], for example, compared the clients' outcome in two different hostels; hostel A was characterized by low EE, hostel B by high EE. Although the same amount of residents relapsed in both hostels, there was a difference in the discharge rate [one in hostel A (12.5%) versus seven in hostel B (63.6%)] for different reasons. Patients in hostel A wanted to live independently, whereas clients in hostel B were mainly discharged for breaking house rules or because they relapsed and had to be admitted to hospitals.

This is quite surprising because clients often have many contacts with other clients, family members and different professional caregivers, and all these people can influence them. Therefore these findings suggest that professional caregivers' attitudes are very important because they can negatively influence their clients.

The reduction of high expressed emotion by training programmes for professional caregivers

Family researchers have developed specific training programmes to teach professionals to decrease the family level of EE [49,50]. These programmes have been successful in increasing professionals' knowledge of schizophrenia [49,50] and in decreasing high EE attitudes among family members [51*]. No information from such studies is available concerning the impact of the training programme on professionals' EE scores.

Changing the attitudes of professionals towards clients has been the focus of two training programmes published so far. The first programme, described in Baxter *et al.* (cited in [52]) and Willetts and Leff [30] is based on the 'Thorn Initiative' course of Lam *et al.* [50] and was set up to reduce community psychiatric nurses' EE. Unfortunately, this programme did not result in a decrease in professional caregivers' high EE attitudes. Also, the second educational programme of Finnema *et al.* [20] was not successful in decreasing the professional caregivers' high EE scores. This may be caused by the fact that these training programmes were very limited in time, and that for this reason they were unable to transfer new attitudes, skills and insights into daily clinical practice. Possibly an optimal tailoring of educational methods and strategies to the needs and demands of participating clinicians could not be realized because of time restrictions of the programmes.

The use of training and education programmes to reduce high EE is a key element in the care of the mentally ill. Future research will have to clarify which features programmes should be included to become effective in reducing high EE among staff, and how these changes can remain stable over time.

Conclusion

As several researchers have already suggested [11,13,53–55] the EE construct is useful for charting the attitudes in interactions between clients and professional caregivers. Although this research line seems promising, it is still limited compared with the large number of family studies. The future of the EE construct in this field will probably depend upon its ability to predict clients' wellbeing, functioning and relapse. Although Ball *et al.* [18] and Tattan and Tarrier [29] found evidence for this association, more studies are needed to confirm these results.

Research findings, however, do not imply that professional caregivers may never show any criticism or hostility towards clients. On the contrary, criticism, and to a lesser degree, hostility, are sometimes needed in order to lift clients towards a higher level of functioning or to maintain the present level of functioning. In order to ensure that this criticism can be constructive for clients, the professional caregivers will have to find the right doses and expression forms and the right time to express it (for example, with humour, also emphasizing the good sides of the clients, at a moment the client is ready for it...). To do this, the support of a team, of training facilities and permanent education possibilities are necessary.

In our opinion it could be an interesting shift in research to consider EE as a team characteristic and not only as a

characteristic of a professional caregiver–client dyad. The interactions between professional caregivers and clients are most of the time part of teamwork. However, the structural and psychological characteristics of the social environment, in which the dyads are situated, and whether they can facilitate or inhibit attitudes of high or low EE, have not yet been studied. In accordance with these points, EE does not only represent a topic for formal individual training programmes. On the contrary, attitudes of criticism, hostility, EOI and role confusion can be elicited and discussed with the team on a regular basis. Processes of intervision can help to detect, acknowledge, recognize and resolve attitudes and the affective team climate that have a negative impact on the functioning and wellbeing of clients.

Also, we think that there can be cross-fertilization between this area of research and the large body of research on countertransference. Until now, only one study has examined the association between these two research lines [56].

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